DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

APPLICATION INSTRUCTIONS AND FORMS FOR A LICENSE TO OPERATE AN ASSISTANT LIVING RESIDENCE IN THE DISTRICT OF COLUMBIA

The information below consists of instructions for completing the application package. Please follow them carefully.

C0MPLETING the LICENSING APPLICATION

Section A. *Residence Name / Demographic*

Enter the legal name (individual or corporation) of the residence exactly as it should appear on the license. Also, enter the name of the contact for the application process. All applicants or persons with oversight and/or day-to-day responsibilities must be at least 21 years of age.

Section A1. *Addresses of the ALR*

Enter the street and mailing addresses of the ALR, to include city, state, zip code, telephone number and e-mail address.

Section B. *Type of Application*

Identify the type of application by checking the appropriate brackets on the application.

Section C. *License and Bed Fees*

Please see General Requirements--D for Table on licensure and resident fees. If the correct amount of fee is not included with the application, the package will be returned to the applicant.

Section D. *Increase/Decrease in Residents*

Applicant completes this section **only if** there is a request for change in the number of residents to reside in the ALR.

Please note that if the entire location is not licensed as an ALR, the area identified as ALR must be indicated on the application form.

Section E. *Application / Owner information*

Enter information on business operations of the ALR. Provide all applicable data.

Section F. *Administrator's Information*

Provide information requested on the administrator or individual responsible for the ALR: name, education, work experience as a direct care provider. The administrator must be 21 years of age.

Section G. Names of Owners of at lease 5%

Identify and enter all business information, as well as everyone who has 5% or greater interest in the corporation.

Section H. Surety Bond

Provide the appropriate documents **if** anyone in the ALR serves as representative payee or power of attorney or will be handling a trust fund for any resident.

Additional Application Forms*

Additional required forms to complete this licensure process include the following:

- A Certificate of Occupancy (seven or more beds)
- A completed, signed, dated and notarized Application
- Cleans Hands Act Certificate
- Verification of Insurance
- Program Statement
- Corporation Form(s), if applicable
- Original Certificate of Good Standing

***Please use the ALR Checklist that has been included as tool to assist you with the completion of the application package**.

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ASSISTED LIVING RESIDENCE (ALR) LICENSE APPLICATION

Please type or print in ink

A. RESIDENCE INFORMATION

Name of Residence | Telephone No. | Fax No.

Street Address | City | Zip Code | Ward

Mailing Address (If Different from Street Address) | City | Zip Code

Contact Person for this Application _____

Address City/State/Zip | Telephone No. | E-Mail Address

B. TYPE OF APPLICATION

[ ] Initial Application [ ] Renewal Application [ ] Revised Application

C. LICENSE & BED FEES

Please indicate resident capacity here_____

1. Enter the standard License fee: ($100.00) (1) $_____
2. Multiply total number of residents by the per residents fee and enter here: ($6.00) (2) $_____
3. Add the amount on lines (1), and (2) and enter here (3) $_____
4. If this is a renewal application mailed less than 90 days prior to license expiration, enter the late fee amount on line (4) here: (4) $_____
5. Add lines (3) and (4) and enter here. This is your total fee. (5) $_____
   (Fees should be calculated based on resident capacity)

D. INCREASE IN RESIDENTS CAPACITY

If this application is only to request an increase in the number of residents (not an initial, renewal, or change of ownership), please complete this section.

Total number of currently licensed ALR residents_____
Total number of residents to be: _____ Increased

If the whole facility is not licensed as an ALR, identify the location or section where additional ALR residents will be located _____
If applying for an increase in the number of residents, multiply the resident fee by the number of residents added and enter total here $_____

E. APPLICANT/OWNER INFORMATION

Applicant is a (n)

[ ] Individual(s)
[ ] Limited Partnership
[ ] General Partnership
[ ] Corporation
[ ] Other (Specify) _____

If the applicant is a limited partnership corporation, list the names, document number, and federal identification number registered with the District of Columbia, Division of Corporations within the Department of Consumer and Regulatory Affairs:

_____
(Name of Limited Partnership/Corporation)

_____
(Address)

_____ _____.
(Document number) (Federal Employer Identification Number)

If a limited partnership/corporation, please attach a current copy of your Certificate of Good Standing issued by the Division of Corporations within the Department of Consumer and Regulatory Affairs.

Is the Corporation_____ for Profit? _____ Not for Profit?

Are the property and building (s) _____ owned by the applicant? _____ Leased or rented? If leased or rented, who is the property owner(s)?

_____
Name Address City/State/Zip Telephone No.

Is the residence to be managed by someone other than the applicant? ____ Yes ____ No, if yes, provide the name of the management company/individual:

_____
Name Address City/State/Zip Telephone No.

You must complete the information below regarding the person(s) who has responsibility for the residence's financial operation.

Name Address City/State/Zip Telephone No.

Complete the following information on each corporate office, director, individual owner, and partner. Attach additional pages if necessary.

If the applicant/owner is a corporation, complete items 1 thru 7 as applicable.

1.

Corporate President Mailing Address City State Zip Telephone #

2.

Corporate Vice-President Mailing Address City State Zip Telephone #

3.

Corporate Secretary Mailing Address City State Zip Telephone #

4.

Corporate Treasurer Mailing Address City State Zip Telephone #

5.

Director Mailing Address City State Zip Telephone #

6.

Director Mailing Address City State Zip Telephone #

7.

Director Mailing Address City State Zip Telephone #

If the applicant/owner is an individual(s), complete items 8 thru 11 as applicable.

8.

Individual Owner Mailing Address City State Zip Telephone #

9.

Individual Owner Mailing Address City State Zip Telephone #

10.

Individual Owner Mailing Address City State Zip Telephone #

11.

Individual Owner Mailing Address City State Zip Telephone #

If the applicant/owner is a general or limited partnership, or other type of ownership, complete items 12 thru 14 as applicable.

12.

_____

Partner Other (specify): _____ Telephone #

_____

Mailing Address City State Zip

13.

_____

Partner Other (specify): _____ Telephone #

_____

Mailing Address City State Zip

14.

_____

Partner Other (specify): _____ Telephone #

_____

Mailing Address City State Zip

Corporations Only: Enter the name(s) and address (es) of each person having at least a 5% ownership interest in the corporation which owns the ALR business (attach an addendum to the application, if necessary). If no person owns at least 5% of the corporation, please enter not applicable.

Name Address City/State/Zip Percent of Ownership

_____

_____

_____

_____

_____

List the name(s) of any facility or other entity licensed by the District of Columbia or another state to provide health or assisted living care with which the administrator or any person listed in this section has been affiliated through ownership or employment within the last 5 years. [**Attach additional sheets if necessary**.]

Name & Type of Facility/Entity:

_____

Address: _____

Dates of Affiliation: _____ Employee? _____ Owner? _____

25% or greater ownership interest _____ Yes? _____ No?

If the facility or other entity closed or ceased to operate due to financial problems; had a receiver appointed; had its license denied, suspended or revoked; was subject to a moratorium on admissions; or had an injunctive proceeding initiated against it, please provide a detailed description and explanation of the occurrence. [**Attach additional sheets if necessary**.]

Adverse Action(s): _____ Yes? _____ No? If yes, description, explanation, and date(s) of occurrence

_____

_____

_____

Does any owner, partner/associate/firm member, officer, or director have at least a 5% ownership interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility? ___ Yes ___ No. If yes, list the name and address of the professional service, firm, association, partnership, or corporation. [**Attach additional sheets if necessary**.]

Name of Business: _____

Address: _____

Nature of Business Relationship: _____

Has the applicant been terminated, permanently suspended, or excluded from the Medicaid programs? _____ Yes _____ No. If yes, please provide a description and explanation

_____

_____

Has any officer, partner/associate/firm member, director, or person owning at least 5% or more of the facility ever been convicted of any offense prohibited by section 435.04, F.S.? _____ Yes _____ No. If yes, please provide a description and explanation:

_____

_____

_____

List three references of whom the agency may inquire as to the owner's, administrator's, and financial officer's character, reputation, and financial responsibility.
Name Address City/State/Zip Telephone #

_____

_____

_____

F. ADMINISTRATOR'S INFORMATION

_____

Name

What date did the above person begin employment with the facility as the administrator?

_____

Does the administrator have a high school diploma or G.E.D.? _____ Yes _____ No

Has the ALR administrator served as a direct care provider or administrator for at least one of the past three years? _____ Yes _____ No

Will the administrator be serving as administrator of more than this ALR? _____ Yes _____ No
If yes, provide the name of the other facilities._____

Name of Facility: _____ License Number _____

Name of Facility: _____ License Number _____

G. NAMES OF OWNERS OF AT LEAST 5%

If the applicant is a corporation, please enter the name for each officer, director, and person having at least a 5 percent or greater ownership interest; enter the name for each member of a firm, partnership, or association; enter the name for each individual owner, administrator, and person having responsibility for the facility's financial operation.

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

H. SURETY BOND

Does the owner, administrator, staff, or any facility representative serve as representative payee or as power of attorney or will be handling resident funds through a trust fund for any resident?
_____ Yes _____ No. If yes, attach a copy of the surety bond or continuation bond.

Signature of
Applicant: _____ Date: _____

Relationship of Applicant to the Assisted Living Residence: _____

I. AFFIDAVIT

I, _____hereby swear or affirm that the information provided in or with this application is true and correct and does comply with administrative and procedural requirements.

Sworn and subscribed to before me this _____day of_____20___.

_____ _____
Notary Public **Signature(s) of Applicant**

_____
Title

My commission expires_____ **(Seal)**

Mail completed application to:

DOH-Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol Street, NE, 2nd Floor
Washington, DC 20002

NOTE: I understand that if I knowingly falsify this application, the Department of Health, Health Care Regulation and Licensing Administration, Intermediate Care Facilities Division (DOH/HCLRA/ICFD) will move to revoke the license for which I'm applying.